BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **TIMOTHY GRAHAM, M.D.** Holder of License No. **23103** For the Practice of Medicine In the State of Arizona.	Board Case No. MD-02-0115A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

On September 4, 2002 Timothy Graham, M.D., ("Respondent") appeared before a Review Committee ("Review Committee") of the Arizona Medical Board ("Board") with legal counsel Winn Sammons for a formal interview pursuant to the authority vested in the Review Committee by A.R.S. § 32-1451(P). The matter was referred to the Board for consideration at its public meeting on December 4, 2002. After due consideration of the facts and law applicable to this matter, the Board voted to issue the following findings of fact, conclusions of law and order.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 23103 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-0200115A after receiving a complaint regarding Respondent's care and treatment of a 74 year-old male patient ("S.P"). On March 10, 2000 S.P. underwent a hip replacement performed by a Dr. Rillos. On March 15, 2000 the hip dislocated requiring a closed reduction. Dr. David, an anesthesiologist assessed S.P. for the March 15, 2000 procedure and determined that S.P. suffered from numerous medical problems, including compromised cardiopulmonary function and

gastroesophageal reflux disease. Dr. David determined that a spinal anesthetic would be the best technique for the follow-up procedure.

4. Respondent assumed care of S.P. on March 15, 2000 as the on-call anesthesiologist. Respondent told S.P. that a spinal anesthetic was contraindicated due to S.P.'s elevated prothrombin time and recommended general anesthesia. S.P. agreed with Respondent's recommendation.

5. In his written response to the Board Respondent defended his use of a general anesthetic with a mask airway for a quick procedure. Respondent noted that in his chart review and assessment of S.P. he concluded that S.P. did not have an ileus. Respondent also noted that S.P.'s prior x-rays revealed only constipation. Respondent noted that he determined that S.P.'s stomach was sufficiently empty prior to surgery and that S.P. did not complain of nausea and did not have a nasogastric tube. Respondent noted that given S.P.'s multiple and severe cardio-pulmonary conditions he was primarily concerned about S.P.'s cardiac status. Respondent noted that he felt that rapid sequence intubation would have increased S.P.'s heart rate and blood pressure and that, since S.P. was thought to have pseudocholinesterase deficiency, prolonged paralysis would have resulted from the succinylcholine required for intubation. Respondent stated that the total time S.P. was anesthetized was three minutes.

6. S.P.'s records indicate that he had an ileus and was not a candidate for general anesthesia. An outside Medical Consultant reviewed S.P.'s records and opined that Respondent did not meet the standard of care in that he did not consider S.P.'s history of gastroesophageal reflux disease and S.P.'s recent use of pain medications after the March 10 surgery as a contraindication to general anesthesia. The Medical Consultant stated that Respondent should have considered that rapid sequence

intubation was used successfully when S.P. underwent the hip replacement 5 days earlier.

7. Respondent stated that the total time S.P. was anesthetized was three minutes. Respondent was asked about his written response to the Board wherein he indicated that Succinylcholine would cause prolonged paralysis and whether Respondent was aware that S.P. had been administered Succinylcholine without complication during the March 10 procedure. Respondent stated that when he reviewed the previous anesthesia records he did not note that S.P. had been administered Succinylcholine without complication during the March 10 procedure.

8. Respondent testified that S.P.'s oxygenation was fine and he believed S.P. was developing acidosis progressively, which was more stressful on S.P.'s heart. Respondent stated that at the time he was treating S.P. he did not believe the signs and symptoms required a rapid sequence intubation and S.P.'s presentation indicated that he was suffering from constipation or gas, rather than a full blown ileus that would affect his stomach.

9. Respondent stated that, when S.P. aspirated, Respondent put in a nasogastric tube and suctioned out the contents of S.P.'s stomach. S.P. then went to the recovery room where he was stable for a time and when S.P.'s oxygen was noted not to be staying high enough, Respondent put in a nasoairway and reintubated S.P. Respondent noted that S.P. went to the recovery room at approximately 5:00 and coded at about 8:00. Respondent stated that in the recovery room he was trying to ventilate S.P. properly and that S.P. seemed to have high peak pressures on his ventilator. Respondent noted there was acidosis due to the inability to ventilate S.P. and have large enough tidal volumes. Respondent noted that there were no beds available in the intensive care unit at that time and S.P. was being ventilated with a portable ventilator in

the recovery room. Respondent stated that S.P.'s heart rate and blood pressure seemed to be doing fine and he believed that S.P. had chemical pneumonitis at this point.

10. Respondent testified that S.P. had a number of issues, including cardiac factors, pulmonary factors and anticoagulation status. Respondent stated that looking at this case now is different from being presented with the patient then. Respondent testified that with S.P. it was not easy to come up with a fail-proof plan. Respondent stated that initially the best thing for S.P. would have been a spinal anesthetic because then there would be no worry about the effect on his heart and lungs. Respondent stated that because S.P. was oxygen dependent he was worried about the effect of intubation. Respondent testified that he also worried about doing rapid sequence intubation on S.P. because of S.P.'s ventricular arrhythmias and atrial arrhythmias and he was worried about giving S.P. medication that would make S.P.'s pulse sink rapidly and blood pressure go too low and then with intubation S.P.'s blood pressure would go too high stimulating S.P.'s adrenal system and stressing S.P.'s heart. Respondent also stated that he felt with S.P.'s pulmonary system it was best to leave the tube out and keep it simple so that Respondent would not have to worry about any complications with S.P.'s lungs.

11. Respondent stated that in looking at S.P. gastrointestinal system, he believes that it was difficult to deal with the way S.P. presented and that if S.P. had come to him with a nasogastric tube in place and if S.P. had been NPO for a day or so, the diagnosis of ileus would have been clear. Respondent stated that S.P. had been up, had been on a regular diet, had a good attitude about completing the procedure and did not seem to be in pain or discomfort when Respondent evaluated him. Respondent stated that based on his review he believed Respondent was constipated as a normal consequence of having had surgery and being bedridden. Respondent testified that it

seemed remote to him that S.P. would develop an ileus. Respondent stated that for all these reasons he felt the best plan for S.P. was to avoid stimulating the cardiac system and that is why he did the mask general anesthetic.

12. The Board Medical Consultant who was present at the formal interview opined that although S.P. certainly had many risk factors, Respondent did not do a careful enough evaluation of S.P. because he did not examine S.P.'s abdomen, did not react to the internist's note in S.P.'s chart that S.P. most likely had an ileus, was not aware of or did not check for the x-ray that raised the possibility of an ileus, and did not make note of the fact that S.P. had a successful rapid sequence induction with Succinycholine just 5 days earlier. The Medical Consultant stated that Respondent was a knowledgeable anesthesiologist who in S.P.'s case did not do everything he should have done to properly evaluate S.P. in that he did not give sufficient credence to the possibility of an ileus by doing the appropriate evaluations and did not use the care and judgment expected from a trained anesthesiologist confronted with a patient with multiple risk factors.

13. The standard of care required Respondent to properly evaluate S.P. prior to the procedure by examining S.P.'s abdomen, reacting to the internist's note in S.P.'s chart that S.P. most likely had an ileus, being aware of or checking for the x-ray that raised the possibility of an ileus, and noting that S.P. had a successful rapid sequence induction with Succinycholine just 5 days earlier.

14. Respondent's treatment of S.P. was unreasonable under the circumstances because, given the standard of care, he was required to and did not properly evaluate S.P. preoperatively because he did not exam S.P.'s abdomen, react to the internist's note in S.P.'s chart that S.P. most likely had an ileus, become aware of or check for the x-ray

that raised the possibility of an ileus, or note that S.P. had a successful rapid sequence induction with Succinycholine just 5 days earlier.

15. S.P. was harmed because Respondent's actions resulted in the selection of an anesthetic technique that resulted in a significant complication and S.P.'s death.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances above in paragraphs 4 through 8 and 10 through 15 constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(24)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public."

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that Respondent is issued a Letter of Reprimand for an inadequate or incomplete preoperative evaluation that resulted in the selection of an anesthetic technique that resulted in a significant complication and a patient's death.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order and pursuant to A.A.C. R4-16-102, it must set forth legally sufficient reasons for granting a rehearing or review. Service of this order is effective five (5) days

after date of mailing. If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 4th day of December, 2002.

ARIZONA MEDICAL BOARD

By _____
BARRY A. CASSIDY, Ph.D., PA-C
Executive Director

ORIGINAL of the foregoing filed this 5th day of December, 2002 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Certified Mail this 5th day of December, 2002, to:

Winn Sammons
Sanders & Parks, PC
3030 North Third Street
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Phoenix, Arizona 85012-3099

Executed copy of the foregoing mailed by U.S. Mail this 5th day of December, 2002, to:

Timothy Graham, M.D.
2393 West 13th Lane
Yuma, Arizona 85364-4376

Copy of the foregoing hand-delivered this
5th day of December, 2002, to:

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